White, W. L. (2013). A life in addiction psychiatry: An Interview with Dr. Herb Kleber. Posted at www.williamwhitepapers.com.

A Life in Addiction Psychiatry: An Interview with Dr. Herb Kleber

William L. White

Introduction

When I have asked people to identify the modern pioneers of addiction treatment, Dr. Herbert Kleber's name is near the top of everyone's list. Only a small cadre of addiction specialists remains whose experience spans work at the Lexington "Narcotics Farm" to decades of clinical practice and research to the highest echelons of drug policy in the United States. Dr. Kleber is a distinguished member of that small fraternity who continues to make significant contributions to addiction treatment and addiction-related policy. I first communicated with Dr. Kleber while working on research for my book, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. He was nothing short of a walking encyclopedia of the field's history and a riveting storyteller. Since that time, I have had the honor of serving on boards with Dr. Kleber and collaborating on several projects. He remains warmly gracious and brilliant. I asked Dr. Kleber in late 2012 to reflect on the modern history and future of addiction psychiatry and the broader field of addiction treatment. Please join us in this discussion of his life and work.

Early Career

Bill White: Dr. Kleber, after finishing your undergraduate work at Dartmouth in 1956, you entered medical school at Jefferson College. What level of training about addiction and its treatment was provided to physicians in the medical schools of the early 1960s?

Dr. Herb Kleber: I graduated from Jefferson in 1960, and I had practically no training in addiction. In fact, I can't think of any. Not only did I have no training in addiction, we didn't really talk much about anything relating to psychiatry. I made the mistake when I started at Jefferson of letting people know I was interested in psychiatry, which did not please many of my medical school professors. I remember my anatomy professor going up to the board to illustrate some particular nerve or muscle and its importance to all the students except "Mr. Kleber, who is going into psychiatry, which raises the question of why he is even here." That was my freshman semester.

That was similar to my father's earlier response. He had dropped out of medical school in his first year, and so from the age of 10 on, I was somehow conditioned to be a doctor. I went to Dartmouth, and I was pre-med and then in my sophomore year, I called home one weekend and said, "Dad, I'm really not enjoying my pre-med courses. I'm planning to drop them and major in philosophy or literature" and my father said, "Well, you've been bar mitzvahed. You're past 13, it's your choice. I'll be up on the next plane." He came up that weekend, and we had a long talk and agreed that I would stay pre-med for the rest of the year and if I still wanted to do it, to give it up, I could do it with his blessing. And then I took my first psychology course and I

said, "Okay. I'll go to medical school and be a psychiatrist." Of course, he never believed that I would follow through on that. He was delighted that I was going to continue on to medical school, but he was sure that I would give up on the idea of psychiatry. When I finished medical school, I went into a psychiatric residency and my father said, "I spent all this money to put you through college, through medical school and you're going to be a psychiatrist? You're not going to be a real doctor?" Unfortunately, he didn't really live to see what I accomplished.

Bill White: How did you come to specialize in addiction psychiatry?

Dr. Herb Kleber: I trusted my government! When I finished medical school and entered into my psychiatric residency at Yale, they were drafting doctors out of residency programs to go to Vietnam. If, however, you signed up for either the military or the Public Health Service, they would let you finish your psychiatric training, or your medical training as the case might be, and you would then go in in your specialty. And so I talked to people at the Public Health Service to see if I could spend my two years at the National Institutes of Health (NIH). To make a very long story short, they said, "Well, go to NIH. See if they want you." I did, and they did, and so I was all set to go there. I was to begin in July of 1964, but in April of 1964, I got a letter from the Public Health Service saying, "We're looking forward to seeing you. You've been assigned to the Public Health Service Prison Hospital in Lexington, Kentucky." And I said, "Wait, wait, we had an agreement. I was supposed to go to NIH." And they said, "Well, call NIH and see if they still want you." So I called NIMH (National Institute on Mental Health) and they said, "Yes, we'd love to have you" and so I called PHS back and they said, "Well, that's fine. Tell them to send someone to Lexington in your place." Uh, they didn't want me that much. And so that's how I ended up at Lexington, which was really in those days the only place that you could learn much about addiction.

Lexington Days

Bill White: Could you describe the treatment at Lexington during your time there?

Dr. Herb Kleber: To begin with, Lexington admitted addicts east of the Mississippi except for women, who came from all over the U.S. The facility in Fort Worth, Texas, took all male addicts west of the Mississippi. Lexington was a unique facility in that it was both a prison and a hospital. It had approximately 1,000 patients housed in facilities spread over 1,000 acres. It had its own farm and its own industries. About two-thirds of the people were prisoners doing one to ten years and one-third were signed in voluntarily but could be more aptly described as "Pressure volunteers." They were under pressure from their medical boards, nursing boards, law boards, or some other coercive force. Many faced the bargain: "if you go to Lexington and stay there until they discharge you, we'll let you keep your license. If you leave before they feel you're ready to leave, you'll lose your license." So you had this mixture living together, the volunteers and the prisoners, some of the best jazz players in the United States at the time.

There were three kinds of treatment. First and foremost, there was what was called "work therapy," i.e., you had a job, which could be on the farm, in the laundry, building furniture, or any number of other things. Everyone participated in that. Second, some had group therapy, and finally a very, very small number of people who received individual therapy. When I was at Lexington, I ran the Receiving Unit, which screened and detoxed all patients when they

came in. The most common drug was opiates, and the most common method of detox was with methadone. We did have some barbiturate addicts who were detoxed using phenobarbital.

I quickly learned that a lot of the male patients volunteered for the laundry because the laundry was a great place to get yourself smuggled into the women's unit. The men would hide themselves at the bottom of the cart that would carry clean towels and sheets from unit to unit so they could get secretly wheeled into the women's quarters. That made the laundry a popular place to be. In fact, much of the disciplinary issues that came up when I was there involved male patients trying to get to the women's quarters in one way or another.

Bill White: Now, during that period, almost anybody that came to be somebody in addiction treatment sort of came through Lexington in those days, right?

Dr. Herb Kleber: Right. Jerry Jaffe, Marie Nyswander, George Vaillant, Everett Ellinwood, Fred Glazer, and numerous other notable addiction specialists had been there, but there were also people who made careers out of it at the Addiction Research Institute. The Institute began at Lexington in 1935 and was really the only place in the United States doing research of that nature in addiction. Some of that talented and distinguished group included Abe Wikler, who did some of the classic studies on conditioning factors, Harris Isbell, Bill Martin, Nathan Eddy, John Ball, and Don Jasinski. I got interested in research through their influence and because I was not happy with the outcome in terms of how well patients were doing when they left treatment.

Bill White: Had the follow-up studies of patients leaving Lexington started by the time you were there?

Dr. Herb Kleber: Yes, George Vaillant had started his follow-up study. I was with Lexington from 1964 to 1966. He was at Lexington from 1963 to 1965, so he had begun his study. But even before George's study, there was some data suggesting that the post-treatment outcomes were very bad. Most of the people who went to Lexington, as high as 90%, relapsed within the first 30 to 90 days of their community reentry.

I was not terribly encouraged by the individual or group therapy I was carrying out at Lexington. When I was at Yale, in my residency, I had done some work on students who were using psychedelics. In fact, one of my earliest published papers (around 1965) was on the prolonged adverse reactions from students' use of hallucinogens. I got interested at that time in LSD therapy and thought that I would do a classic before-after study. If you looked at the literature at that time, it broke down into two groups. There were therapists who had had personal LSD experiences who were reported to get good group therapy outcomes and therapists who did not have past LSD experiences whose outcomes were reported to not be good at all. So I decided I would not take LSD, run a double-blind group with an active e placebo (dexedrine) and track outcomes, and then I would have an LSD experience myself and then replicate the first study with a different group of individuals.

As I was finishing that first group, Sandoz recalled the LSD. It had become a street drug, and they did not want to be associated with it. And so they asked those researchers who had LSD supplies to return them to Sandoz. I had enough that I could have taken it myself, but I no longer had a scientific reason for doing so. So I decided not to go ahead with that, and I returned the LSD. I did follow up with that first group with questionnaires gathered from the people where they lived in the housing units, or from the supervisors in the Work Unit, and in general, most of

the people did not seem to change very much. I was not terribly impressed with the outcome of the study.

Bill White: If you look back over your time at Lexington, were there lessons gained that influenced your later work?

Dr. Herb Kleber: Oh yes. One, I learned that this was a very difficult group to treat. They were individuals who were there under pressure and were there either because they were prisoners or they were pressure volunteers, and they were not terribly interested in changing. Our job was to try and get them to change, and we didn't get very far with that. Two, I learned that the techniques then used in treatment were not very effective and that new approaches to treatment were desperately needed. Three, I also learned a valuable lesson from George Vaillant. I was having a difficult time getting permission to do the LSD study and asked George for advice. He said he had also had a difficult time getting permission for his studies until he got on the committee. I followed his example, and that's how I got permission to do the research.

Yale University Drug Dependence Unit

Bill White: When you left Lexington, you went to Yale to start its Drug Dependency Unit. This was before NIDA and NIAAA were founded.

Dr. Herb Kleber: Yes, when I returned to Yale in 1966, I wasn't interested in treating addicts but everyone kept seeking me out—addicts who wanted help, doctors who wanted someone to refer to, parents worried about their children. So in 1967, I applied to NIMH to continue my LSD research. (There was no NIDA or NIAAA then.) I remember Roger Meyer, who ended up as my NIMH project officer, saying, "Herb, it's an interesting proposal, but how do we know you're going to be able to get patients for this study? You have no addiction treatment going. Why don't you revise your grant and include state of the art treatment and research?" He wanted me to study treatment and then pursue my LSD research interests. I did the former and never got around to doing the latter.

Bill White: How would you describe the state of community-based addiction treatment in the late 1960s?

Dr. Herb Kleber: Well, it didn't exist, and some people didn't want it to exist. My Yale department acting chair at that time, Ted Lidz, did not like the grant and did not want me to submit it. He said the $500,000 a year for five years was too much money for a young faculty member and that he did not think the Department of Psychiatry should be treating addicts. His position was that if I wanted to treat addicts, I should join the School of Public Health. Fortunately, having learned from my patients at Lexington that there's always more than one way to get things done, I found out the key people on his executive committee and met with all five of them, one at a time. I asked if they had any family history of alcohol or drug problems and if they were concerned about the rising use of drugs by adolescents. The chair was out-voted five to one. So I applied for the grant and received it in 1968. By then, Vince Dole and Marie Nyswander had already begun methadone maintenance, so one of the things I started was a methadone program.

Bill White: I remember that Yale, Chicago, and a few other places were the first to develop multi-modality addiction treatment systems. Could you describe how communities accepted those early modalities and how those modalities perceived and related to each other?

Dr. Herb Kleber: There were five of those early multi-modality systems, including ours in New Haven, Jerry Jaffe's in Chicago, Ray Knowles' in St. Louis, and Bill Wieland's in Philadelphia. It was a very turbulent period with a lot of community resistance. For example, the District Attorney in Philadelphia said that he would arrest any physician who prescribed methadone for the program. They didn't go that far in New Haven, but there were some difficulties, and these were not just limited to methadone treatment.

We worked with David Deitch, who headed the New York Daytop program (the earliest therapeutic community derived from Synanon). David had agreed to help us start a Daytop in New Haven as the first one outside of New York. They sent a small team of people, both staff and senior patients, to get things started. Then about three months later, Daytop in New York imploded. They fired David Deitch. I remember getting a call one night from a reporter saying, "Dr. Kleber, what's this I hear that there are 200 New York narcotic addicts heading for New Haven?" Since we were the only other Daytop around, a lot of the patients wanted to stay with the staff they were familiar with, so they came to New Haven. The facility that we then had only accommodated twelve to fifteen people so we quickly scrambled to get as many volunteers as we could to house them in their own homes. I had people living in my house until we finally could find a facility.

I guess we were more accepting than in Philadelphia; at least no one threatened to arrest my doctors. I was fortunate enough to recruit some very good staff. Our initial programs included methadone detox and maintenance, residential care at Daytop, an adolescent outpatient program, and a street storefront facility run by recovering addicts who had been patients of mine at Lexington. The overall program expanded from that base. When it was clear the outpatient adolescent program didn't work, we went into an adolescent day program, then an adolescent residential program and then we started a vocational program. We kept adding as we needed to become the full-fledged program that could meet the needs we were encountering. We also set up a good research facility that tried to look at what we were doing and see whether it was having any effect.

Bill White: This was also a time where there was a great hostility between TCs and methadone maintenance programs. Was that the case in New Haven?

Dr. Herb Kleber: Not as bad as elsewhere because of our central command structure. We even set up a central intake, staffed by representatives of each program, that would decide which program you went to. But elsewhere it was bad. I remember going to early conferences and when someone would get up and speak about TCs, the methadone people would walk out. When methadone advocates spoke, the TC people walked out. It was much as you have described in your articles. Nothing much had changed.

Bill White: I seem to also recall you referencing some interesting interactions with the Black Panther Party during this early period.

Dr. Herb Kleber: Yes. They were not happy with what we were doing. They threatened to burn down our facilities because they felt what we were doing was not of ultimate good for the ghetto. In their view, all we were doing was putting a Band-Aid on the problem of addiction because we were not addressing problems of racism and discrimination in such areas as housing and employment. Needless to say, we did not close, and our facilities were not burned down.

Early Research Activity at Yale

Bill White: A number of clinical breakthroughs emerged from your clinical work and research during these years. Could you describe some of that early research and some of those early innovations?

Dr. Herb Kleber: Sure. As noted, we started with an outpatient adolescent program, and when that wasn't enough, we added a day program. We found, however, that what we were providing by way of psychosocial support wasn't enough. Too many of our patients were relapsing in the hours they were not with us at the program. That's when we first began to use narcotic antagonists. The only one available at that point was naloxone—a short-acting, poorly absorbed oral antagonist that we gave in dosages of 800 milligrams orally a day, over 800 times the amount needed I.V. to reverse an opiate overdose. That provided an 18-hour blockade effect that was just enough to get our patients back to us heroin-free the next day. Then we tried cyclazocine, which was a mixed agonist-antagonist, but it had a number of adverse side effects. Then we started using and evaluating naltrexone around 1972.

The original manufacture of naltrexone was bought by DuPont, who saw no future in naltrexone, so they decided to close it down. But having learned a few things from my Lexington days and my work with addicts, we contacted people we knew at the *New York Times* and *The Washington Post*, and we scheduled a press conference for three weeks hence, in which we would label DuPont a "war profiteer." Our argument was that DuPont was making large profits on what they were selling to the military in Vietnam but that our poor brave soldiers were coming home addicted to narcotics while DuPont was putting profits ahead of treating these individuals. We sent a copy of the letters to DuPont, and a week before the press conference, they caved and agreed to keep making it. We were able to continue our naltrexone treatment and research.

Bill White: One of your early interests—I'm thinking of a paper you did with Charles Riordan—was that of harm in the name of help within the history of addiction treatment.

Dr. Herb Kleber: That collaboration with Charlie grew out of our research in 1978 at Yale on the use of clonidine in the management of opiate withdrawal. This was led by Mark Gold, who was just finishing his psychiatric residency at Yale and who is now Chair of Psychiatry at the University of Florida. Mark, Gene Redmond, and myself found that clonidine, which was on the market as an anti-hypertensive, was effective in treating the symptoms of opiate withdrawal. Clonidine is an alpha-2 adrenergic agonist, and our theory was that a lot of the symptoms in withdrawal came about from over-activity of the locus coeruleus. What the clonidine did was fool the locus into believing there was already enough adrenaline on board so it would markedly decrease it, which treated about 80% of the withdrawal symptoms. It wasn't perfect, but it was reasonably effective. (The theory behind clonidine's mechanism of action came from George

Aghajanian at Yale.) As part of that work, Charlie and I reviewed the historical study of opiate detoxification. That was where this discovery of the long history of harm in the name of help originated. Our history of opiate withdrawal built on the work that Kolb and Himmelsbach had done earlier at Lexington. They found that at the turn of the century, detox was considered cure. If you relapsed, it was because you lacked moral integrity.

Some of the techniques used in withdrawal were absolutely horrendous. In one paper using bromide sleep treatment, 2 out of the 10 subjects died, and the conclusion was you should only use it in well selected patients. And my thought was, who do you select, your brother-in-law whom you don't like, or what? There was another one, I think it was scopolamine, where the advice was to only use on the first floor of the hospital with a strong attendant constantly present because people were becoming psychotic and falling or jumping out of the window. Or sodium thiocyanate where patients became wildly delirious and psychotic, with psychosis lasting up to two months. There are a number of studies like that one, each perhaps worse than the other. And the relapse rate was very high, which led then to the opening of the maintenance clinics around 1914, where either morphine or heroin was given to confirmed opiate addicts. They didn't have any long-acting opiates at that time for effective maintenance. The clinics closed by 1925 under pressure from law enforcement. The then predecessor of today's Drug Enforcement Administration (DEA) began to prosecute doctors who continued to prescribe opiates to addicts, and my memory is that between 1925 and 1940, there were 25,000 doctors arrested for such practices, with about 10% of them sentenced to prison. The rationale for closing the maintenance programs was that they didn't lead to abstinence—a similar complaint one hears today about methadone and buprenorphine maintenance.

Training Physicians in Addiction Medicine

Bill White: During your Yale years, you were also teaching. Did you see education of physicians and psychiatrists about addiction advancing during those years?

Dr. Herb Kleber: Oh yes. Our division opened in 1968 and by 1989 when I left, we had over 750 patients maintained on methadone and a total of over 1,000 in treatment. We had a large Naltrexone program. We had our own adolescent therapeutic community. We had an adult therapeutic community. We had all sorts of ancillary programs and a lot of research going on, psychological, pharmacologic, and epidemiologic. We had a wonderful group of young faculty, including Tom Kosten, Rich Schottenfeld, Bruce Rounsaville, Kathy Carroll and Stephanie O'Malley. They were exciting people to work with, and I would probably still be there if I hadn't gotten this offer to join the federal government in 1989. The physicians being trained at Yale had the opportunity to do important work. We did some of the earliest research on Naltrexone. Right before DuPont took naltrexone to the FDA in 1984, they discovered that no one had ever done the study to see if you got tolerant to the antagonistic effects. No one had bothered to study the long-term antagonist effects of Naltrexone. So we quickly mounted a study. We brought doctors who'd been on Naltrexone for a couple years (as part of their treatment for narcotic addiction) into our laboratories, and we studied their responses to doses of narcotics and naltrexone. We published a paper confirming that you did not get tolerant to the antagonist effects of Naltrexone. Bruce Rounsaville did important studies on psychological aspects, including dual diagnosis, as well as several follow-up studies. Tom Kosten was forever pursuing different pharmacologic techniques of treatment. We also were one of the first research centers

to study cocaine in 1982 with the leadership of Frank Gawin and Tom Kosten. We developed in the early 1980s rapid opiate detox, combining naltrexone and clonidine, under the leadership of Dennis Charney.

Bill White: You must be quite proud of such a distinguished group of researchers coming out of Yale during your tenure that went on to contribute to the field for years to come.

Dr. Herb Kleber: We were very fortunate. We had a very good program, and it attracted Yale students. We taught a lot in the medical school and in the residency, and we were able to interest people in making a career in addiction treatment and research. Kathy Carroll, for example, came to me in 1986 needing a thesis topic. I had just come from a NIDA conference on relapse prevention, and I still had all my material from the meeting. I gave them to Kathy and I said, "This is a great area for you to get involved in," and she became one of the world's experts on relapse prevention, CBT, and related methods. Our administrator, Roz Liss, started with our Yale program in 1968 and was one of the key persons holding the unit together and getting the work done.

Bill White: Another of your milestones at Yale was APT Foundation.

Dr. Herb Kleber: I started APT, which stands for the Addiction Prevention Treatment Foundation, in 1970 or 1971. One of the grants we were applying for required a match, and neither Yale nor the State of Connecticut was interested in putting up the match. So I went to movers and shakers in New Haven, including the major Italian, Irish, Jewish, Black, and Puerto Rican leaders. I told them what I was trying to do and said, "I know you may be too busy to serve on this foundation board, but I would appreciate it if you could name somebody that would serve on the board so that when they vote, I know they're speaking for you." And all of them said, "I'll serve."

That was a very important lesson for me about how to involve the community. Support from those leaders became very useful when everyone from the Black Panthers to Yale wanted to shut down methadone treatment. Yale leaders were afraid that if the Feds would cut back on their funding of methadone, the university would be put under pressure to make up for the withdrawal of funds. I met with the key people at Yale and I said, "Well, I'm a loyal Yale faculty member and so when 5,000 angry citizens march on the university, I will be out there with them saying, "Don't burn that building. That's the President's house." Well needless to say, we did not close the program and the President's house did not burn, but there was continued resistance due in part to the fact that at one point, APTF had more grants than we did through Yale, which meant that Yale was losing a lot of overhead. We had four or five million a year in APTF grants going through NIH and so they said, "You know, we'd like you to close APTF." I said, "I don't know why you're talking to me. I don't run APTF. I don't get any money from APTF. I'm an unpaid consultant to the Foundation. If you want to talk to APTF, you should talk to the editor of the newspaper, the head of the bank, et cetera." And as you can gather, APTF did not close. Those background experiences were all very important when I think about getting into the federal government and what needed to be done at a community level to generate support for addiction treatment.

Bill White: Did your presence at Yale also constitute a challenge to prevailing psychiatric practices of that era?

Dr. Herb Kleber: Yes it did. I recall being asked to do grand rounds at the Yale Psychiatric Institute, which in the 1970s was one of those very expensive, long-term psychiatric facilities. It was headed then by Ted Lidz. In the 1970s, they were still using psychoanalytic techniques. The case they presented to me was of a sixteen-year-old girl who was hospitalized there because of her LSD use. The resident presented the case, and I then interviewed the young woman and then she left the room, and I turned to the group and I said, "This is malpractice. It should be reported. You have been treating this young lady for six months and you heard me ask her if she's still doing LSD and she said, 'Yes' and if she's still smoking marijuana and she said, 'Yes,' she does it almost daily. She gets it from other people who go out on pass and you've done nothing about it." And the head of the Institute said, "Dr. Kleber, you don't understand the nature of what we do. We need to let people act out so that we can deal with it." I said, "How can you deal with it? You didn't even know she was doing it." When the resident presented the case, there was no mention of her doing drugs. They didn't know until I asked her. Needless to say, I was never invited back. At that time, psychoanalytic theory was still very important, but that's not psychoanalytic theory; that's just poor practice.

The Office of National Drug Control Policy

Bill White: In 1989, you received an invitation to become the Deputy Director of Demand Reduction at the White House Office of National Drug Control Policy. How did this opportunity arise?

Dr. Herb Kleber: I had gotten divorced in 1986 and a year or two later, I had met a young woman who was a professor of psychiatry at Johns Hopkins, Marian Fischman, who had done some of the pioneering cocaine research. We had started one of those long-distance commuting relationships. She would come to New York on weekends or I would go down to Washington or Baltimore. Then I get this call out of the blue from Bill Bennett's staff. He had just been confirmed as the new drug czar—a position created in the waning days of the Reagan presidency. When Bush became President, he was not terribly interested in it, but Congress was. Bennett's staff called me and told me about the office, which I'd never heard of, and asked if I'd be willing to apply for the job of Deputy for Demand Reduction. And with the arrogance of a Yalie, I said, "I'm very busy. I'm not sure that I could come down to Washington for an interview and besides this, I'm leaving this Saturday for a meeting in Hong Kong"—a meeting Marian and I were planning to attend. His staff said "Well, look, he's gonna be in New York in two days. Would you be willing to go to New York and meet him there?" And I said, "Sure." So I went to New York and I met with Bill and his staff, and it was about a two and one-half or three hour meeting. The next day, I got a call offering me the position.

Marian was opposed to my taking the position because the salary was just a little bit more than my alimony. Between my alimony and social security and paying for rent and food and all of that in Washington, there was no way I was going to be able to live in Washington. I ended up going into debt for $200,000 via a bank loan. So I told the government people that I really needed to think about it and that I would call when I got back from Hong Kong. So Marian and I talked about it the whole plane trip over, and we agreed it could be interesting. So, I called and

accepted the position. I found out later, by the way, that the person who had nominated me was someone I had never met—the wonderful New York Senator, Patrick Moynihan. He knew of me because whenever his staff had any questions about addiction, they would call me. The position required Presidential nomination and Senate confirmation.

Bill White: Now, what are your most vivid recollections of your work at ONDCP and what that experience was about for you?

Dr. Herb Kleber: Well, I first learned that it wasn't so easy to get the job. The parents movement was well under way at that time and one group, Pride, was hoping to get one of their own named for that position. So they tried to use their influence to block my nomination. They sent all sorts of letters to the White House saying that I was the wrong person. I was too liberal. I was in favor of medications, etcetera, etcetera. But other community folks countered that with a deluge of letters of support sent to the White House as well as scientific societies so that President Bush finally said, "Okay. We'll nominate him." So needless to say, my experiences in dealing with diverse communities and groups without compromising my own principles were something I took with me into the White House. When I got there, I also learned that there are some very important mottos that I could rely on. The key motto in Washington is, "We'll double-cross that bridge when we come to it." Or, "in Washington, where there's smoke, there's mirrors" or Peggy Noonan's classic remark, "In Washington, if you want a friend, get a dog." I had to learn the culture of Washington and how to get things done in Congress.

Bill White: Any other recollections?

Dr. Herb Kleber: I recall that in the waning days of the Reagan presidency, he held a White House Conference for Drug-free America, and Pride was very active at that meeting. One of the things they had done at that meeting was to demand an investigation of NIDA because it favored methadone and was supporting methadone-related research. The meeting came out in opposition to methadone. So, one of the earliest things that we did at ONDCP was to issue a White paper on treatment in which we reviewed all the different types of treatment including pharmacologic approaches, psychological approaches, etcetera, and pointing out the strengths and the weaknesses for all of them. And we said, "Methadone can be a very important contribution to a comprehensive drug treatment program."

At this same time, we fostered the development of local community groups around the whole problem of drugs. The key person was Sue Rusche from Atlanta. She had been one of the key people that opposed Pride when Pride tried to block my nomination. She founded National Families in Action, which started family groups in communities all across the country that did some very wonderful work.

Bill White: How was ONDCP structured while you were there?

Dr. Herb Kleber: Bill Bennett was the overall director. Then there was John Walters, the Chief of Staff, and then there were three deputies. I was the Deputy for Demand Reduction. There was Stan Walters, the Supply Deputy, who had been the head of the U.S. Marshals and Reggie Walton, who was a federal judge and was the Deputy for State and Local Affairs. We divided the Demand Reduction division into an Assistant Deputy for Prevention (Donna Rigsby) and an

Assistant Deputy for Treatment (Phil Diaz). These people knew the communities, and they knew what was going on at HHS.

A major problem I encountered was that the chief of staff did not want us meeting with any members of Congress without his permission and without one of his staff present. And I thought, "Hell, if I followed those kind of rules, I'm not gonna get any work done." So, I would quietly go behind their back and get X done by meeting with so-and-so." There were a number of significant accomplishments the Office made while I was there but that would take a whole chapter to describe the local, national, and international contributions. A small domestic example was revamping the major data sources. Monitoring the Future at the University of Michigan was started in 1975 but only surveyed 12th graders. We expanded this this mandate to include 8th and 10th graders so we could see what was going on at the younger ages. The National Household Survey was done very three years and had a relatively small number sampled. We made it yearly and markedly expanded the size to get a better national picture.

Columbia University Division of Substance Abuse

Bill White: When you left ONDCP, I believe your next step was to found Columbia's Division on Substance Abuse.

Dr. Herb Kleber: That's correct. The Division began in July of 1992, six months after I arrived. When Marian came here from Hopkins, she brought with her two colleagues, Richard Foltin and Suzette Evans, and we also hired a psychiatrist, Frances Levin, who had been trained in addiction at the University of Maryland. So that was the original core group: the five of us, plus Ned Nunes, who was here for years but was not really full-time in addiction. He was primarily in the Depression Unit. These five positions were part of my dowry from Columbia to start the division. And then we started writing grants as we figured out what we wanted to do. Marian replicated her human behavioral laboratories, and Fran Levin, Ned Nunes and I began the focus on clinical research. Our first grants enabled us to set up a training center that included an addiction fellowship program and established a center for medication development. Both of these programs are approaching their 20th year. This funding from NIDA really jump-started the division. We went from that small initial core group to somewhere between 120 and 130 individuals at present. The Division encompasses research "from the bench (basic science) to the bedside (clinical research)" and includes both PET and MRI imaging research.

Bill White: You've been involved for more than 20 years in investigating medications in the treatment of addiction. What are some of the important findings from this research?

Dr. Herb Kleber: Well, let's take it drug by drug. In terms of marijuana, for example, our laboratories under Meg Haney were the first to demonstrate that physical dependency could occur with marijuana use. Before that, marijuana was considered a psychological addiction but not a physical one. Our laboratories showed that there was a clear-cut withdrawal syndrome, one of the reasons why so many people later relapsed following various psychosocial interventions for marijuana dependence. So, once we decided that we were dealing, not just with a psychological dependence, but also a physical one, we then began to try a variety of medications to treat it. We've tried some of the THC substitutes that are approved by the FDA, medications such as Dronabinol and Nabilone. We've tried them alone and in combination with other

medications such as naltrexone and lofexidine. I think we're developing some useful psychopharmacological approaches to the treatment of marijuana dependence.

With the opiates, we did some of the pioneering work on Buprenorphine, with Sandy Comer doing the Behavioral Lab studies and Richard Foltin, Suzette Evans doing the animal studies and Fran and Ned the clinical studies. Buprenorphine was finally approved in 2002 by the Food and Drug Administration and put into Schedule III in contrast to methadone, a Schedule II drug. Being in Schedule III made it possible for doctors to prescribe it in an office-based practice, which you cannot do with methadone for maintenance. Buprenorphine has done an awful lot of good. There's certainly some diversion of it, but I think the net result is a positive one. There are currently about 275,000 Americans on methadone maintenance. Buprenorphine was approved, as I noted, in 2002 but basically didn't hit the pharmacies until 2003. There are now over 375,000 people maintained on Buprenorphine. So it's helped an enormous number of people get their lives together. What made that possible was the passage of a bill by Congress in 2000 called, "DATA," the Drug Abuse Treatment Act. And it was DATA that made it possible for physicians to prescribe Buprenorphine once the FDA had classified it as a Schedule III drug. I used some of the contacts I'd made as well as knowing how Washington worked to help with the passage of DATA. In addition, we're trying some interesting combinations to treat cocaine and have recently published the findings. Marian oversaw all of this, especially since my time was split between Columbia and CASA.

Bill White: Dr. Kleber, in a related area, I'm recalling that wonderful retrospective piece you recently published on the history of methadone maintenance in the treatment of opiate addiction. Could you share your views on that history and the current status of methadone maintenance in the United States?

Dr. Herb Kleber: Yes, that was the JAMA [*Journal of the American Medical Association*] paper. Well, if you remember when Vince Dole first started his methadone maintenance programs, the Feds tried to close them down. Fortunately, he'd lined up some of the top New York law firms to help him, and he was able to keep his program going. Many programs that followed Vince also faced considerable challenges. Beyond Vince and his team, the person who played the biggest role initially in the spread of methadone maintenance in the United States was Jerry Jaffe, who served as the drug czar under Richard Nixon. Jaffe convinced Nixon that if he was going to be a law and order President, he needed to make methadone maintenance more widely available and to respond to addicted veterans returning from Vietnam. This is all described very nicely in David Musto's book, *A Hundred Years of Heroin*.

Bill White: How do you view this split between the clinical research on methadone maintenance versus the continued stigma at public and professional levels linked to it and recent political moves to restrict availability of methadone, or in some cases even recommending that methadone programs be closed?

Dr. Herb Kleber: Yes, and that includes Senator John McCain, whom I otherwise greatly admire. He introduced a bill, I think in 1999, that basically would have prohibited methadone for any longer than six months. Fortunately, that bill got tabled, sent to committee, and never saw the light of day. But I believe he still holds to that position. There's still a lot of stigma attached to methadone linking to this image of "giving dope to dope addicts." I think part of the problem

is that currently, 90% of the methadone programs in California and I think 60% nationwide are private-for-profit, and the only way you really make money running a methadone program is if you decrease the number and the training of staff, so that psychiatrists become internists become psychologists become social workers become basically recovering counselors with caseloads of 60. I've been in the field for many years—I could not handle a caseload of 60.

You have a group of people who disagree with the concept of methadone maintenance, and then you have people who might be neutral or even supportive of methadone maintenance but who object to what they see as a very poor quality of such treatment. There has been concern, for example, by people like New York Mayor Giuliani about the lack of community reintegration of methadone patients, as exemplified by low rates of employment of MMT patients. The stigma attached to methadone may not change until some of these broader outcomes are addressed as part of methadone treatment, as was more likely the case in the early days of MMT; however, there will always be individuals who view methadone as one T.C. director did in the '60s: "I think methadone is a great idea. We should give money to bank robbers, women to rapists and methadone to addicts." Many view methadone and buprenorphine as simply maintaining the addiction. Opposition especially comes from programs and individuals espousing AA and the 12-Step movement. Many of them view these agents as simply substituting one addiction for another. You have eloquently written about such criticisms yourself.

CASA Lessons

Bill White: During your years at Columbia, you also served as Executive Vice President and Medical Director of CASA. What are some of the important lessons you took from your involvement in CASA?

Dr. Herb Kleber: Joe Califano was able to assemble an extraordinarily distinguished board of directors and raise an enormous amount of money for CASA. CASA began around 1992 with a grant from the Robert Wood Johnson Foundation, and I think it now has about a $50 million reserve. And they've come out with some very interesting policy papers—most recently a large volume on the treatment of addiction in the U.S.—that points out the large gap between our knowledge base and what actually happens in most programs. I think they've done some good work in a number of areas. I left CASA when my wife got quite sick. Marian died from cancer in 2001 in the fall, and I left CASA around the end of 2000 because she was finding it increasingly difficult to spend the amount of time and energy on the division up here. I was half-time between CASA and the program here at Columbia. And as you know yourself, two half-time jobs is like three full-time jobs. So I don't feel I did as good a job at either Columbia or at CASA by being half-time each. It will be interesting to see where CASA goes from here now that Joe has retired as Chair.

Professional Writing

Bill White: When I mentioned to other people that I was going to be interviewing you, many wanted to know how on earth have you been such a prolific writer given all the other demands on your time?

Dr. Herb Kleber: As you go along in life, you make choices, and one of the choices I made was the importance of my work in my life. So when I would come home in the evening, I often continued to work after dinner. I certainly didn't get any writing done during the day. I did my writing at night and on the weekends. Having married early, my children were all in college or out by the late 1970s which made it possible to work evenings without stinting on time with them. So, now, of course, my kids are all grown. My baby now is 49. So I have the three children and their spouses, six grandchildren, and I now have my first great-grandchild, and in retrospect, it would have been nice to spend more time with the kids after they grew up and the grandkids. But you make some choices in life. And I loved what I was doing. I really did enjoy it. I didn't see it as a sacrifice. I saw it as a labor of love. In spite of that, my children have all turned out to be wonderful, warm, successful, and loving human beings.

The Press, Medical Marijuana, and Agonist Therapy

Bill White: You've often been brought into contact with the press and the media on some of the most controversial issues in our field. Do you have any reflections on your encounters with the media that you could share with others of us who find ourselves in those kinds of circumstances?

Dr. Herb Kleber: Well, first assume that anything you tell reporters is gonna get out there. There are no secrets. Some reporters are better than others at respecting, "off the record." But in general, I don't say, "Off the record." I say what I mean, and I'm comfortable when they print it. I try and give my positions in a clear, logical way without the emotionality. There are certain things I feel very strongly about, and I do not hesitate to communicate such feelings.

Bill White: Your recent publications on the use of marijuana in medicine would be one such example?

Dr. Herb Kleber: Yes, I was recently asked to write a commentary for the *American Journal of Psychiatry* on this subject. It was entitled, "Physicians and Medical Marijuana," and it argued that physicians have no business being involved in this arena at all. We cannot as physicians prescribe something where the dose, the frequency, the duration, potency, and the purity are unknown. When I prescribe Prozac, I know exactly what I'm prescribing. You know, 20 milligrams once a day, and it's FDA-approved and we assume that it's pure; it's not contaminated and that if I say twenty milligrams, that's what you get. With medical marijuana, you have no notion of what the person is going to get. I believe there are important constituents in the marijuana plant that could eventually become FDA approved agents. But "Medical Marijuana" programs are not the way to go.

My favorite article on medical marijuana was an interview by a *New York Times* reporter of a physician in Colorado. The reporter was allowed to sit in on an interview with a patient requesting medical marijuana. The whole thing took less than five minutes, and there were basically two questions and no hands-on physical. "Do you have any conditions for which marijuana might be helpful" and the person answered, "Yes, my back is killing me." And, "Do you have any condition for which marijuana might be harmful?" "Of course not." "Go out and see my assistant. Pay her $150, and she'll give you the medical marijuana card." And after the individual left, the doctor turned to the reporter and said, "I made a million dollars last year working only three days a week and the wonderful thing about this law is you need a new card

every year." So, I have little respect for most of the physicians that are involved in medical marijuana. There are some conditions for which marijuana might be quite helpful. They're limited and in fact, of the people in Colorado or California, less than 3% are taking the medical marijuana for any condition in which it has been shown to be helpful. That's one of the things I feel very strongly about and I'm happy to give interviews to reporters about it. To serve in such a role means that you have to stay abreast of all the latest research. My files on marijuana articles and policy issues take up a whole, huge filing cabinet drawer.

I also feel strongly about the role that agonists can play in the treatment of opioid dependence. One of the papers I want to write and which I have presented in a number of grand rounds is entitled "Opioid Agonists: Terminable or Interminable?" in which I argue that most of the people who get on drugs like Buprenorphine need to stay on them for years and that if they get off, the relapse rate and the overdose rate is very high. Eighty-two percent of the people who leave methadone maintenance are injecting opiates within one year. So there's very good data that indicates the relapse rate is high—going back to Bill Martin's discovery in the 1950s at Lexington of a "protracted abstinence syndrome" (PAS) in opioid addiction that persists as much as six to nine months after your last dose. This is a physiologic withdrawal expressed psychologically in the form of sleeping difficulties, decreased energy, trouble concentrating, weird dreams, and most important, trouble coping with stress. I think the PAS is one of the reasons why the relapse rate is so high when you get off an agonist, and we're doing research now figuring out ways to get around the PAS.

I had symptoms very similar to opioid-related PAS when I gave up smoking in the mid-1970s. I'd been smoking for about 25 years, and my children were very upset. They kept saying, "Daddy, we don't want you to die." And I kept making lame excuses and then finally, I said, "Okay, I'm gonna stop." I tried on my own, I failed. I went to a hypnotist, failed. And finally, joined something called, "Smoke Enders" that Jackie Rogers had started. And that worked. It was a five-week program, and I think Jackie was way ahead of the times in developing a variety of techniques to help people cope with the various symptoms when you stop smoking at a time medications were not available to help with smoking cessation. Those methods worked for me, but for six months, I had trouble writing grants and papers and also had trouble sleeping. That's the period when most people resume smoking. Interestingly, we've discovered that marijuana withdrawal is identical to tobacco withdrawal, with one major exception: when you give up smoking, you gain weight; when you give up marijuana, you lose weight. Other than those effects on appetite and weight, the two withdrawal syndromes are very similar.

Career Reflections

Bill White: When you look back over what has now been a very long career in addiction psychiatry, what do you feel best about?

Dr. Herb Kleber: I feel my major contribution has been the legacy of the people I've mentored who are still in the field and very productive. The group at Yale still consists of a lot of the people I trained when I started the division there. And likewise, we have a wonderful group of people here at Columbia that I have mentored and others who I mentored at Yale and Columbia who have gone to other places. Many of these people will go on to make more important contributions than I've made.

Bill White: How do you approach young people who are exploring working in the addictions field?

Dr. Herb Kleber: Well, first, I want to find out why they wish to work in the field. Is this an intellectual interest? Is it about a family member who had or has a problem with addiction? I try and get some feel of why they're interested and then expand on that in terms of what a wonderful field it can be. Then I let them know it will not be easy and what he or she is likely to encounter. I talk over the options with them regarding their relative interests in basic research, clinical research, or primary clinical practice. I love research, but I also am happy to turn out well-trained clinicians who love to treat patients and who are good at it. It's been fun offering such guidance. I tell my young faculty that I have one of the greatest gifts that God could give a person, which is waking up every morning and looking forward to what I'm going to do. That includes seeing patients as well as the research and the mentoring.

Bill White: You know, in fact, that's probably my final question that I want to pose to you because I've so greatly admired this incredible enjoyment you have of your work and the very warm relationships you had with people at all levels of the field, and many people when I've mentioned your name have asked me how you've maintained that vitality and optimism in a field that you and I both know can really chew people up if they're not very careful in terms of how they manage their role in it.

Dr. Herb Kleber: Let me tell you one of my favorites quotes. The deputy drug czar position required Presidential nomination and Senate confirmation. I was a Republican nominee of President George H.W. Bush, and the Senate committee was chaired by Ted Kennedy, so it was a rigorous committee meeting. Near the end, Senator Kennedy said, "Well, Dr. Kleber, you've been in the field for many years. How have you managed to keep up your optimism and energy and enthusiasm?" No one had ever asked me that. So I thought for a moment and out of the blue came a Talmud quote that I had read many years before: "The day is short. The task is difficult. It is not our duty to finish it. But we are forbidden not to try." Now, how do you ask nasty questions after that? My group at Yale asked me what they could give me as a going away present. And I said I'd love to have that quote framed so I can put it on my office wall in Washington and a week later, my administrator called and said, "I can't do it." And I said, "Why" and she said, "Because you misquoted it. You left out a line." I said, "I know I left out a line." "The day is short, the task is difficult. The workers are lazy." There was no way in hell I was gonna quote that third line. So, we compromised. I'm still looking at that quote because it's on my wall here. It is my quote. And at the bottom, it says, "The Talmud as misquoted by Herb Kleber."

Bill White: [Laughing] What a wonderful story. That's a wonderful place for us to end our interview. Dr. Kleber, thank you for taking this time to explore your life's work. Thank you for all you've done on behalf of individuals and families seeking recovery. And thank you for being a friend and mentor these many years.

Acknowledgement: Support for this interview series is provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse

Treatment (CSAT). The opinions expressed herein are the view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.